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K A N S A S

KANSAS HEALTH POLICY AUTHORITY

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To: Members of the Kansas Health Policy Authority (KHPA) Board
From: Marcia Nielsen, Interim Executive Director of the KHPA
Re: FY 2007 AND FY 2008 KHPA Legislative and Policy Options – Revised List with Board Actions
Date: August 18, 2006

Please find enclosed the Legislative and Policy Options which were reviewed and voted upon during Tuesday's Board meeting. Specific action taken by the Board has been noted at the bottom of each summary sheet. In addition to these one page documents, the accompanying spreadsheet that outlines the program/policies and their associated costs has been revised to reflect the following changes:

1. From the FY 2008 Enhancement list to the Non-State General Fund for FY 2007/2008 category: Immunizations Registry, EPrescribing study, and Drug Partnership study.
2. From the FY 2009 Funding Consideration list to the Non-State General Fund for FY 2007/2008 category: Pay For Performance and Create a Nurse Help-Line.

Tier I: Programs or policies funded through a **Supplemental Request for FY 2007.**

Policy Option: Increase Staff and Support Infrastructure for KHPA.

Description: Increase the funding for KPHA staff (through Full Time Equivalent (FTE) positions) and infrastructure commensurate with operating an independent agency.

Background: The initial support infrastructure available to KHPA should be enhanced in order to adequately support an independent agency and to operate as the single state agency responsible for the Medicaid program. Staffing levels, particularly in the Finance & Accounting and Operations areas, are particularly in need of resources. Adequate staffing ensures that the Authority is able to protect the financial integrity of the programs it administers and to provide meaningful management information. Currently, some resources have been diverted from program areas to improve financial and operational support, however, this has not been sufficient to address all needs. Internal transfers have also left some program areas with limited functionality . Administrative resources such as space, are also well below many of our peer agencies and are limiting functional capacity . A comparative review of staffing levels of 4 other agencies in December 2005*, showed that for similar finance & operations functions, the Budget/FTE ratio was $4.5M of budget per Operations FTE. Within DHPF at the time, that ratio was $38.1M per FTE. We neither expect nor desire to achieve parity in such administrative ratios, but our assessment is that without additional resources to the agency, the financial integrity of the program could be jeopardized.

There are several reasons additional resources are needed at this time. When the initial levels of staff and budget transferred upon creation of the Division of Health Policy and Finance, they were not sufficient to properly staff an independent agency. A key reason is that the Department of Administration was providing the infrastructure support to the Division of Health Policy and Finance until July 1, 2006. They continue to provide a limited number of administrative services through a Memorandum of Agreement. However, now that the Authority is an independent agency we are in need of additional staff and resources to support our mission. In addition, the KHPA Board determined that a needs assessment for funding of an independent agency be conducted by the Division of Health Policy and Finance rather than request additional funding from the legislature in the 2006 session. This needs assessment is reflected in the proposed increase in funding for staffing and infrastructure described here.

Population Served: Internal Support for all KHPA programs; Division of Budget, Accounts & Reports, etc.

Consideration: At the testimony provided to the Oversight Committee in March 2006 by Dr. Nielsen, she explained that we would be conducting a needs assessment to more realistically determine our staffing and finance needs and would be bringing our requests to the legislature in the 2007 session.

Cost: On attached document.

Recommendation: Request supplemental budget consideration for FY 07 for additional staff and operating expense space requirements.

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** (Aging, Commerce, Corporation Commission, SRS were considered – Activities included Accounting /Budget/ Fiscal Management/ Claims Processing; Audits; Customer Service; Federal Reporting; Grants & Contracts Management; Human Resources; Leadership; Legal; Purchasing; Facilities & Support Services; Records Management; Recoveries & Debt Setoffs. Not included are IT and Data Management related functions since the IT infrastructures are not comparable. Only central office staff were counted)*

Board Action: Motion made, seconded and carried to approve for Supplemental FY 2007 funding for 42 positions.

Policy Option: Addition of staff to the Clearinghouse – for FY 2007

Description: Add staff to the Medicaid Eligibility Clearinghouse to process applications within the mandated timelines and conduct quality reviews of HealthWave determinations.

Background: The number of applications and annual reviews for Medicaid beneficiaries in Kansas increased by an average of 1,089 per month between 2004 and 2005. Some of the work is outsourced and the contractor, pursuant to the terms of the contract, has sent KHPA a request for additional staff to accommodate the increased workload. Moreover, by federal law all Medicaid eligibility determinations must be finalized by state staff. Accordingly, as the number of eligibility application increases, both the contractor and the state need additional state staff to manage the increasing workload within mandated timeframes.

Population served: Any applicant for Medicaid medical benefits.

Considerations: The KHPA has already exhausted all potential trade offs, such as using funds specified for other projects, within the terms of the contract. In addition, the recent July 1 implementation of the citizenship verification requirements required by CMS for Medicaid beneficiaries is increasing the amount of time it takes to process applications and will exacerbate the delays due to the increased workload. These delays may result in concerns expressed to the legislature and the Governor regarding the timeliness of the processing. Delays in enrollment would also result in a lower Medicaid caseload. This outcome could be incorrectly interpreted as an intentional budget control measure for Medicaid enrollment. Finally, Medicaid beneficiaries may not be able to access services when needed, which could have a significant impact on pregnant women and newborns in Kansas.

Cost:
Add five additional staff for contractor. This is a yearly cost and the same funding is needed for FY08 and FY09

All funds	FFP	**SGF**
$350,000	$175,000	**$175,000**

Add four additional state staff. This is a yearly cost and the same funding is needed for FY08 and FY09; FTE slots are needed.

All funds	FFP	**SGF**
$224,000	$112,000	**$112,000**

Staff Recommendation: Fund for Supplemental Request FY 2007.

Board Action: Motion made, seconded and carried to approve for Supplemental FY 2007 funding.

Policy Option: **Complete Enhanced Care Management Pilot for FY 2007**

Description: Complete the Enhanced Care Management (ECM) pilot project in Sedgwick County. This project works with community resources to improve the quality of care and appropriate health care utilization by adult Medicaid beneficiaries with chronic illness.

Background: ECM is an enhanced primary care case management program that uses a chronic care model. This model combines intensive case management and disease management techniques to serve the needs of individuals with multiple, co-occurring chronic conditions. ECM clients are identified through the Medicaid Primary Care Case Management program, HealthConnect. Data about the clients, including paid health claims, demographic information, and diagnostic information are processed through modeling software to provide a risk probability reflecting the likelihood of high volume or high cost health care needs. These risk scores are used to target outreach from the ECM project staff to recruit participants for care management.

The ECM project was originally developed in response to a specific recommendation from the 2003 Senate President's Task Force on Medicaid Reform. The project is delivered through a contract with the Central Plains Regional Health Care Foundation. Central Plains is an extension of the Sedgwick County Medical Society and has developed partnerships with hospitals, physician practices, and clinics. Over the last six years, Central Plains has provided services to the uninsured and has experience with evidence based utilization strategies. Medicaid staff have been working with Central Plains on the structure of the ECM project since 2002 and completed contract negotiations in 2005. Central Plains started providing services through the ECM project on March 1, 2006.

In addition to providing direct care management, the ECM project includes an external evaluation by Trajectory HealthCare LLC. Trajectory has been engaged to review the quality of care provided through ECM and to measure changes in health outcomes among participants. The evaluation design includes a comparison group of beneficiaries in another county to measure the effectiveness of the care management intervention. Reviews of preliminary data will be conducted throughout the project to ensure that opportunities to adjust the program design are recognized early and implemented quickly.

The program is currently an opt-in model authorized under the state plan with a 50% match rate. Service delivery to enrolled members began March 1, 2006. Evaluation of the project is claims based and includes a reference population from Wyandotte County.

Population Served: ECM draws from the enrolled members of Medicaid primary care case management population, HealthConnect, who reside in Sedgwick County. Population served under the program after January 2007 will be Supplemental Security Income (SSI) and General Assistance (GA).

Consideration: The estimated cost of the contract was approximately $2.0 million per year (5 year contract term).
However, the 2006 Legislature reduced the FY 2007 budget for ECM from $1.9 million to $1.5 million (All Funds). The State General Fund reduction was $900,000, leaving only $600,000.

Cost: $750,000 from the State General Fund to fund the existing contract for the full year of FY 2007.

Staff Recommendation: Fund for Supplemental Request FY 2007 and end the pilot project. After the evaluation and analysis of the program is complete, we should determine the effectiveness and feasibility of expanding a disease management model throughout the state. The goal of such a program would be to increase the health of those who are chronically ill and, in the long term, decreasing overall health care costs.

Board Action: Motion made, seconded and carried to approve for Supplemental FY 2007 funding.

Policy Option: Extension of Community Health Record Pilot Project

Description: Extend the Community Health Record (CHR) pilot program in order to obtain adequate information to evaluate the impact of the information technology on Medicaid providers and beneficiaries.

Background: The former Division of Health Policy and Finance entered into a collaborative pilot project with our Medicaid managed care plan, FirstGuard Health plan, and Cerner Corporation, a Kansas City based information technology company. The goal of the project is to deploy community health record (CHR) technology to FirstGuard Medicaid managed care providers in Sedgwick County. The CHR is built on administrative claims data and provides clinicians electronic access to claimed medical visits, procedures, diagnoses, medications, immunizations and lead screening data. We are currently working to enable the transfer of lab results to the CHR. The CHR also has an ePrescribing component that provides a drug interaction and contraindication tool, along with formulary information for the prescriber along with the capability to submit prescriptions electronically to pharmacies.

FirstGuard currently covers approximately 14,000 Kansas Medicaid managed care members in the Sedgwick county area. The pilot involves twenty FirstGuard provider sites throughout the county, with over 200 trained users and 18 trained ePrescribing users as of August 2006. The project was launched in February 2006 and is set to end December 31, 2006. Due to the several month ramp-up period to train users and implement across provider sites, the program has been in operation at most sites for six months or less.

An independent evaluation of the CHR will be conducted. Tom Wilson, Ph.D., Trajectory Consultants, has been engaged by KHPA to perform the evaluation. The evaluation will have a lag time of approximately six (6) months from the project end date, in order to assess all relevant claims data.

Population Served: Kansas Medicaid managed care members in Sedgwick County.

Considerations: Feedback from provider sites has been very positive, especially regarding the medication history component. Emergency rooms, which in the past would have been faced with treating patients with little or no information, have also provided very positive feedback regarding the access to information through the CHR. Both FirstGuard and Cerner have been excellent partners for this pilot project.

Cost:
Project Funding: **$125,000 SGF** for remaining FY 2007; $250,000 All Funds.

Evaluation: **$25,000 SGF** for FY 2008 to fund expense for independent evaluation.

Staff Recommendation: Fund for Supplemental Request FY 2007 and end the pilot project. Fund the independent evaluation for FY 2008. After the completion and analysis of the independent evaluation, consider the development of an RFP process to open a Community Health Record for Medicaid beneficiaries and/or the State Employee Health Plan for FY 2009.

Board Action: Motion made, seconded and carried to approve for Supplemental FY 2007 funding but to delete the words "…and end the pilot project…". This project and funding will be revisited by the Board again in six months.

Tier II (A) Programs or policies funded through an Enhancement for FY 2008.

Policy Option: Expand access to care for children though the creation of a "Healthy Kansas First Five" Program

Description: Expand health care coverage to children age 5 and under from low and moderate income families who lack health care insurance by expanding low-cost insurance options through HealthWave.

Background: The need to provide a healthy start in life through prenatal care, early detection and screening is well documented. Healthy Kansas First Five is a measured approach to expanding health insurance coverage to Kansans that need it most. Nearly 11% of the Kansas population is uninsured, and most of these live in households with at least one worker. As the cost of health insurance continues to rise, an increasing number of working Kansas families cannot afford health insurance. Those working in small businesses are less apt to be offered insurance, and those with low and modest incomes often have difficulty affording health insurance. We estimate that approximately 15,000 Kansas children five years old and younger are uninsured.

This initiative ensures that all children in Kansas have access to affordable health insurance during the first five years of life, and is designed to significantly reduce the number of uninsured children in that age group. To accomplish this, KHPA proposes to expand the upper income limit for the HealthWave program from the current level of 200% of the poverty level (yearly income of approximately $32,000 for a family of three) to 235% of the poverty level, and to create a state-only HealthWave option for young children in families up to 300% of the poverty level. Both components require families to pay an affordable premium related to their level of income. Above 300% of poverty, families would be allowed to enroll their children at the full actuarial cost. To remain within Federal spending limits for the HealthWave program, this proposal may require that some families with incomes between 133% and 200% of poverty be transferred from Title XXI HealthWave to Title XIX Healthwave coverage. To maintain the linkage with their newborns, Medicaid eligibility for pregnant women would also be increased to approximately 185% of poverty, increasing expectant mothers' access to prenatal care.

Population Served: This program will cover uninsured children ages 0-5 years who are citizens and residents of the state of Kansas. Approximately 2,000 children would be served in the first year of operation (2008), with additional enrollment expected thereafter.

Cost Estimate: FY 2008 $4M – $6M Annual cost SGF

Considerations: This initiative was included in the Governor's budget but was not funded by the legislature in FY 2006. Legislators cited the need to wait for the new Health Policy Authority Board to set the agenda and weigh in on this proposal. Presenters in two of the Board's three townhall meetings offered support for this proposal.

Revising the Medicaid State plan will require CMS approval and extended planning and start up time. Any changes made in the income eligibility guidelines will affect the State Children's Health Insurance Program federal funding allotment, which is capped in each state. Congressional action on SCHIP reauthorization is expected in 2007. Major program changes will require computer systems changes within the MMIS and KAECSES systems, and at the HealthWave clearing house.

Staff Recommendation: Fund for Enhancement for FY 2008.

Board Action: Motion made, seconded and carried to approve for FY 2008 Enhancement funding.

Policy Option: Coverage of Dental Services for Adults in Kansas Medicaid

Description: Expand coverage of dental services to adults in the Kansas regular Medicaid program.

Background: Recent evidence based studies have shown a relationship between periodontal disease and premature births and cardiac disease. Avoidance of even one premature birth can save the State from future years of medical services and disability payments. Poor oral health not only poses risks to physical health, but often leaves cosmetic evidence of poverty. Kansas should cover a wider array of dental services for adults enrolled in Medicaid. As stated above, several serious and expensive health conditions are related to periodontal disease, costs would decrease in these areas as the oral health of Medicaid-eligible Kansans improves.

Currently for adults in Kansas Medicaid only emergency dental services are covered, such as, extractions for infected teeth, excision of tumors, and the diagnostic work related to these services. In September of 1993, adult dental services were cut to save less than half a million dollars of the state general fund budget. In December of 1998, the current adult dental coverage was initiated to offset increased costs to emergency rooms for adult dental services.

Population Served: Adult Medicaid beneficiaries currently eligible for dental services.

Costs: $3,515,000 State General Fund (SGF); $8,787,000 (All Funds)

Based on fiscal year 2006 data, there are 152,800 additional individuals eligible for adult dental services. The average dental expenditure in fiscal year 2006 for clients aged 18 through 20 was approximately $60.00 per person.

Some cost containment could be implemented through limiting services, such as capping the amount of services per year. However, there may also be some offset savings as adults with oral pain would visit their dentist rather than an emergency room (ER) and as preventive dental visits limit the severity of conditions and reduce ER utilization.

Considerations: Access to dental care is an increasing issue in Kansas. According to the study by the Kansas Health Institute, *The Declining Supply of Dental Services in Kansas: Implications for Access and Options Reform*, completed in January 2005, the supply of dentists in Kansas "is expected to decline steadily and significantly over the long run." A number of policy issues have been suggested to help address the problem, such as loan repayment plans, increasing the number of dental school graduates, subsidies for students that require practice in underserved areas, and consideration of changes to state laws to allow independent or generally supervised practice by dental hygienists and/or mid-level practitioners.

Members of the 2006 legislature were focused on dental access issues and a dental residency program at Wichita State University was created by the Legislature last session. Adequate Medicaid reimbursement for dentists is also a concern for some organizations as dental provider reimbursement affects participation. The Legislature in 2006 approved funding for adult dental services to be provided to beneficiaries who receive services through the Developmentally Disabled (DD) and the Physically Disabled (PD) Home and Community Based Services Waivers (HCBS) waivers. In addition, the legislature commissioned a study for the KHPA, due in March, 2007, to compare dental care provided by a capitated managed care program versus fee for service in Kansas Medicaid.

Staff Recommendation: Fund for Enhancement for FY 2008.

Board Action: Motion made, seconded and carried to approve for FY 2008 Enhancement funding.

Policy Option: Expand Eligibility and Health & Wellness Outreach Efforts for Medicaid

Description: Expand the marketing of programs available to the public in order to educate Kansans about health and wellness and ensure that individuals eligible for Medicaid and SCHIP are participating in the program through: (1) designing an online application and screening tool for potential beneficiaries, (2) developing and implementing a targeting marketing campaign and (3) employing additional outreach workers.

Background: Identifying uninsured families has long been a goal of Kansas, and the placement of outreach workers at key locations throughout the community will increase the awareness of the opportunity for coverage. As families obtain coverage, they are more likely to access preventive medicine including well child visits, immunizations, and dental care. In Kansas in 2004, there were approximately 36,000 children who are eligible for Medicaid but not enrolled. (In comparison, there are currently approximately 164,000 Kansas children enrolled in Medicaid).

As society becomes more dependent on the Internet to share information, Kansas should invest in the creation of an on-line application/screening tool. This would allow for the more accurate submission of applications, development of an interface with the clearinghouse system for an immediate eligibility determination, and reduce the need for clearinghouse staff to "key" the applications. With the issuance of laptop computers to the outreach workers, a potential member could get assistance with application submission at an access point. The screening tool could be used to quickly determine if a person should complete an application and utilized by designated entities as the presumptive eligibility determination tool.

Adding health and wellness education as a part of a public marketing and Medicaid enrollment campaign provides an opportunity to share health information with potential Medicaid beneficiaries, with the goal of increasing healthy behaviors and reducing overall health care costs. It is estimated that 75% of all health spending is dedicated to those with chronic diseases, which are significantly related to lifestyle choices.

Population Served: As the core focus of these new positions will be outreach, and health and wellness promotion is considered a portion of the duties, these new staff will serve all Kansans. However, their main duties would revolve around assisting adults and children in the completion and submission of the HealthWave application.

Cost Estimate: SGF $441,636; FFP $441,636; Total $882,272

- Staff - $416,272 (increase staff by 8 positions)
- Laptop Computers $2000 x 8 = $16,000
- Online application/screening tool – Development $350,000
- Marketing dollars - $100,000

Considerations: The recruitment of energetic self-motivated outreach staff would be key to the success and efficiency of this initiative.

Staff Recommendation: Fund for Enhancement for FY 2008.

Board Action: Motion made, seconded and carried to approve for FY 2008 Enhancement funding.

Policy Option: **Develop a Data Management and Policy Analysis Program**

Description: Provide for the effective management and use of health data in Kansas in order to promote data driven health policy decisions that improve health care efficiency, lower health care costs, and improve overall health status. This requires the resources necessary to purchase effective data management tools, such as a data analytic interface, and hire appropriate staff to provide data analysis for policymakers and stakeholders and to ensure dissemination of meaningful data to external users.

Background: The statute creating the Kansas Health Policy Authority (KHPA) charges the Authority to provide to a variety of stakeholders data that reflects the utilization and cost of health care services purchased by the State and by other public and private entities. These data are vitally important in developing a coordinated statewide health policy agenda. Together with the creation of the Data Consortium (page 19), KHPA will use and disseminate this data in partnership with stakeholders to ask and answer important health policy questions pertaining to affordability and quality of health care and health status of Kansans. In addition, KHPA must make decisions about the management of health care benefits for Medicaid/SCHIP beneficiaries and for state employees, while balancing access, cost, and quality. Finally, the KHPA is charged with formulation of broad policy recommendations in health policy, a mandate that goes beyond the program-oriented charge of the organizations that were brought together to comprise the KHPA staff.

To effectively support data-based decision-making, as well as to meet the Authority's statutory responsibilities to provide data to stakeholders, the Authority is proposing to contract for the development of a common data analytic interface that will bring various data sets together and provide Authority staff with tools to access the data quickly and in more meaningful ways. These data sets include:

- Medicaid
- SCHIP
- State Employees Health Plan
- Kansas Health Insurance Information System – KHIIS
- Health care professional licensing information, and
- Hospital discharge data.

In addition to the analytic interface for KHPA staff, KHPA requests funding for five additional policy analyst positions, as well as additional funding for consulting and external analytical support. The consulting and external support will be used when questions are especially complex, require special expertise, or when staff resources are not available. These funds will also help to create and sustain a broader community of invested data users who can contribute to the improvement and application of this valuable data to improve health policy in the state.

Population served: All Kansas citizens should benefit from these resources because they will help the KHPA more easily make policy decisions based on data and will facilitate dissemination of information to a wide range of decisionmakers and consumers.

Cost estimate: $600,000 (SGF); the annual cost will be about $2,000,000 (All Funds) for FY 2008.

Considerations: CMS may pay an enhanced match rate on the acquisition of this system if it approves an Advanced Planning Document (APD) that will be submitted by KHPA; the SGF portion could be significantly smaller due to the enhanced match rate. Assessments and fees collected for the databases that have transferred to the Authority will be available to help fund this proposal. In addition, the Authority will apply state employee health benefit funds since the employee health benefit data, currently accessed through a separate interface, will be included in the proposed system.

Many members of the legislature have called for the increased use of data to drive health and health care decision making. Using data to analyze the efficiency and quality of health care services will enhance the ability of the State to better control health care costs in the public and potentially private sector, as well as increase quality of care.

Staff Recommendation: Fund for Enhancement for FY 2008.
Board Action: Motion made, seconded and carried to approve for FY 2008 Enhancement funding.

Policy Option: Develop a Long Term Care Partnership Program

Description: Adopt a Long Term Care (LTC) Partnership between KHPA, as the Medicaid agency, and the Kansas Insurance Department (KID) to encourage people to purchase LTC insurance policies. With an approved Partnership, individuals purchasing certified LTC policies can have the value of the insurance benefit disregarded from consideration for Medicaid eligibility. This allows people who would have applied for Medicaid to access payment for nursing facility care to delay enrollment and to protect some of their assets from consideration for eligibility or estate recovery.

Background: Only certified LTC policies qualify for the Partnership benefit. To be certified, the policy must meet specific requirements established by the Centers for Medicare and Medicaid Services and be endorsed by the Kansas Insurance Department (KID). According to the Insurance Department, LTC policies sold in Kansas currently meet most of these requirements, but not all policies will qualify under the Partnership. KHPA will rely on KID to certify LTC policies that would be allowed under the Partnership plans.

Insurance agents will have to be trained about the implications of different LTC policies on Medicaid eligibility. KHPA will need to provide information about Medicaid eligibility rules to ensure agents have an understanding of Partnership policies.

Population: Seniors with LTC needs would be most directly impacted by the change, as they would receive the benefit of the resource disregard. However, the Partnerships are designed to encourage additional people to purchase LTC insurance before the benefits actually are needed.

Cost: No estimates are available at this time. By encouraging the purchase of LTC insurance, the state may reduce Medicaid expenditures by delaying Medicaid eligibility while the long term care insurance benefit is used to meet service needs. Administrative changes will be required, which could require additional cost. These include staff training, modifications to the automated computer system, and implementing required reporting process.

Considerations: Kansas has an existing state law exempting LTC insurance payments from Estate Recovery. Fewer than 25 families have taken advantage of the exemption in 10 years. Both the Kansas Department on Aging, as the agency responsible for nursing facility administration, and SRS, with responsibility for eligibility determination, will be involved in the development of the Partnership with KHPA and KID.

There are only five states that have operating Partnerships. The federal Deficit Reduction Act (DRA) allows additional states to submit Medicaid state plan amendments to created LTC Partnerships. There is widespread support in the Kansas legislature for utilizing this DRA flexibility.

Staff Recommendation: Fund for FY 2008.

Board Action: Motion made, seconded and carried to approve for FY 2008 Enhancement funding.

Policy Option: Health Information Transparency for Consumers

Description: It is proposed that KHPA establish a two phase health information transparency initiative that will (I) initially collect and make available existing health and health care data resources to the Kansas consumer and (II) collect and publicize Kansas specific health care quality and cost information measures developed by the Data Consortium for use by purchasers and consumers.

Phase I: KHPA will establish a partnership with the Kansas state library and other interested libraries and stakeholders to facilitate consumer access to reliable health information to enable consumers to make optimal health care and wellness decisions. KHPA and the libraries consortium will develop a portal to improve access to currently available health information, complete a statewide environmental scan of health information and develop long term initiatives to meet the need of Kansas consumers, and build a health information curriculum to help Kansans on using health information to improve their health and utilization of health care, with a focus on quality and cost. The partnership will then develop a consumer health/healthcare professional portal consistent with the standards established by National Library of Medicine (NLM) to deliver health information to all geographic areas of the State.

Phase II. After the development of Kansas specific health quality and cost measures recommended to the HPA Board by the Data Consortium (which consists of health care stakeholders in Kansas), the KPHA will make available to the public measures allowing consumers to compare cost and quality of health providers and plans. Several other states have such programs, such as Minnesota and Wisconsin, which we can utilize in designing a Kansas specific model.

Background: Transparency in today's health care environment refers to the development of standardized provider performance metrics, outcomes reports, and pricing information to be shared with the public. Consumers currently have limited access to meaningful information from which informed health decisions can be made. As result, there is little assurance that consumers are receiving an optimal return on investment when purchasing health care services. Publishing standard pricing and quality information can empower consumers and purchasers to use resources more efficiently and drive them to providers that offer the highest quality care.

A number of health information library-driven initiatives are underway across the country to facilitate consumer access to health care information. In 2004, the NLM announced that over 40 projects in 24 states were funded to improve consumer access to reliable and authoritative electronic health information. The American Libraries Association (ALA) also announced their partnership with Walgreens in 2004 to promote consumer health education and libraries as a source of health information. Initial efforts focused on providing public libraries with information to increase knowledge and understanding of the Medicare Drug Discount Card Program. Currently, the Medical Library Association (MLA) offers a "User's Guide to Finding and Evaluating Health Information." The guide incorporates the collective wisdom of medical librarians who regularly search the internet for quality information in support of clinical and scientific decision making by doctors, scientists, and other health practitioners.

Cost Estimate:
Phase I: $150,000 SGF. Cost for library staff to develop portal, development of model search engine for Kansas consumers, and develop curriculum/training for using health information.

Staff Recommendation: Fund phase I of this proposal for FY '08. Further cost estimates will need to be developed for phase II for FY '09 upon development of health indicators of quality and cost information for consumers and purchasers.

Board Action: Motion made, seconded and carried to approve for FY 2008 Enhancement funding.

Policy Option: Provide Childhood Obesity Counseling through Kansas Medicaid

Description of Policy: Create incentives for primary care providers to monitor body mass index, diet and physical activity for Medicaid eligible children.

Background: Medicaid providers are currently required when billing for a KanBeHealthy (KBH) screening of a child, to weigh and measure the child, as well as calculate the child's body mass index (BMI). Kansas Medical Assistance Programs (KMAP) currently cover two codes, through KBH, that could be used to provide dietary and nutritional counseling to the child. These codes can be billed by physicians and dieticians, but not by mid-level practitioners such as physician assistants or ARNP's. In addition, they cannot be billed on the same day as an office visit and only pay at $20. Opening up these service codes to a wider range of practitioners, raising the reimbursement rate, allowing them to be billed along with an office visit, or some combination of these three would help to combat obesity in children served by KMAP.

Recent research findings regarding childhood obesity (Thomson 2006, MEDSTAT Brief).

- Children covered by Medicaid are nearly six times more likely to be treated for a diagnosis of obesity than children covered by private insurance,
- Children treated for obesity are roughly three times more expensive for the health system than the average insured child,
- Annual healthcare costs are about $6,700 for children treated for obesity covered by Medicaid and about $3,700 for obese children with private insurance,
- Children who receive Medicaid are less likely to visit the doctor and more likely to enter the hospital than comparable children with private insurance,
- Children treated for obesity are far more likely to be diagnosed with mental health disorders or bone and joint disorders than non-obese children,
- Children diagnosed with obesity are two to three times more likely to be hospitalized. (Both privately and public insured)

Population Served:
Kansas currently serves 163,885 children under Medicaid. The adults present in the lives of these children should also be considered as part of the population to be served.

Cost Estimate:
$589,986 (SGF) $1,474,965 (all funds). This assumes 30% of the children served by KMAP would be seen for a medical therapy nutrition visit once a year, at $30 per visit.

Considerations:
Kansas enacted nutritional standards for schools, nutritional education and physical activity, recess or physical education (SB 154) in an effort to address childhood obesity. The Kansas chapter of the American Association of Pediatricians is working, along with the KMAP KBH Manager to develop tool kits about recognizing and treating childhood obesity and improving nutrition in children. These tool kits will be distributed to every physician and every KBH provider in Kansas.

KMAP does not currently collect obesity related data. Mechanisms to receive or require this data are not established. The impact of targeting children with an educational focus on obesity may not be realized for many years. Stakeholders should be prepared to wait for long-term measures, although states like Arkansas are already seeing some short term successes with their childhood obesity programs. Additionally, adults are the primary decision makers for shopping, meal preparation and lead by example for activity and exercise.

Staff Recommendation: Fund for FY 2008 or FY 2009.

Board Action: Motion made, seconded and carried to approve for FY 2008 Enhancement funding.

Policy Option: Link the state immunization registry with the Medicaid Management Information System (MMIS) to target immunizations for all eligible beneficiaries.

Description: Establish a link between the KDHE Immunization Registry and MMIS. This link would allow for claims submitted by Providers to automatically update the immunization status of beneficiaries listed in the registry through a "data dump" of MMIS immunization claims date into the registry. The registry contains immunization information on all beneficiaries, not just children, so all information regarding immunizations will be used to populate the registry, giving us immunization data across the life span of Medicaid beneficiaries. KDHE, KHPA and EDS staff are in the process of getting the link operational. We anticipate that the link will be operational this year.

Background: Immunization rates for Kansas children do not meet national standards. In 2004, Kansas ranked 43rd out of the 50 states in the nation for the percentage of children between the ages of 19 months and 35 months who had received their full course of vaccinations for childhood preventable diseases. The Governor convened a blue ribbon task force on immunizations and the determination was made to fully develop an immunization registry, which is called WEBIZ. A recent initiative, Immunize Kansas Kids, has been launched by the Kansas Department of Health and Environment and the Kansas Health Institute to research barriers to improvement of immunization rates and develop an action plan for Kansas. The initiative to link the immunization registry to the MMIS system is designed to supplement these efforts.

Population Served: General Kansas population.

Cost Estimate: $8,263 State General Funds;$33,054 All Funds for MMIS modifications. KDHE has incurred the cost for the procuring the registry. When the current MMIS was designed, the option of establishing this link was designed into MMIS.

Considerations: Establishing this data link would assist in accomplishing immunization goals set forth the Kansas 2010 Healthy People goals, provide current beneficiary immunization information to providers and provide more complete immunization information for HEDIS reports.

Staff Recommendation: Fund for Enhancement for FY 2008.

Board Action: Motion made, seconded and carried to remove this option from the FY 2008 Enhancement package and instead include in the "Non-State General Fund Program and Policies" for FY 2007/2008 implementation, in conjunction with a budget proposal from KDHE related to expansion of immunization registry.

Policy Option: Health Information Exchange Initiatives

Description: As the coordinator of health policy for the state, the KHPA should continue to be a leader in statewide HIE projects, and support HIE initiatives in other agencies as well, through information sharing and collaboration.

Background: Health information exchange (HIE) has the potential to improve efficiency, quality of care and patient safety as well as help inform health care consumers. There are a number of ongoing statewide health information exchange initiatives sponsored by the Governor's Health Care Cost Containment Commission (H4C) that the Kansas Health Policy Authority (KHPA) staffs or is involved in, as well as initiatives being led by the agency or other state agencies, like Kansas Department of Health and Environment's (KDHE) public health information exchange (PHIX).

Current HIE initiatives KHPA oversees or is involved in:

- **Kansas HIT/HIE Policy Initiative** – This is a multi-stakeholder, statewide project that will develop recommendations for the creation of a HIE infrastructure for Kansas. Four working groups will begin meeting monthly for the next six months (Sept. – Feb.) to address Governance, Financial, Technical and Clinical issues and formulate recommendations for sustainable HIE infrastructure. Kansas is one of a handful of states this far along in HIE planning. eHealth Initiative Foundation was contracted with to facilitate and manage this project for Kansas. KHPA provides project oversight on behalf of the H4C for this initiative and will provide $30,000 in direct support in FY 07. Support from Sunflower Foundation, UMHM Fund, and Kansas Health Foundation ($165,000 in total foundation funding, split equally across the foundations) has enabled this project.
- **Privacy and Security Collaboration** – KHPA staff partnered with the Kansas Health Institute, KU Center for Healthcare Informatics, Mid-America Coalition on Healthcare and Lathrop & Gage to submit a proposal on behalf of the Governor's H4C. Kansas was one of 34 states awarded a subcontract with RTI/NGA to address variations in business practices and policies around HIE, develop solutions to address barriers to HIE and an implementation plan. Kansas was awarded $305,000 for the project, with partners providing more than the award in in-kind support. The project timeline is May 2006 through March 2007.
- **Advanced ID Card Project** – The H4C commissioned this project to achieve two goals: 1) gain consensus from Kansas health plans on standardized health plan ID cards (MACHC guidelines) and 2) gain consensus from Kansas health plans to develop standards for advanced ID card technologies (e.g. magnetic stripe, bar code, etc.). Data from a previous H4C study on claims payment problems revealed that the majority of claims problems resulted from coverage issues that could be reduced or eliminated with the use of advanced technologies on the ID card. The Mid-America Coalition on Healthcare was engaged to complete this work. The KHPA is funding ($45,000 FY 06 and $45,000 FY07) and providing oversight for this initiative.
- **Community Health Record (CHR) Project** – KHPA implemented this pilot project in partnership with FirstGuard (FG) health plan and Cerner. The CHR is built from administrative claims data and is a web-based tool that presents the clinician with an individual's medical history, medication history, immunizations, allergies, and lead screening data. The tool also has an ePrescribing component that provides drug interaction and contraindication checking providing to submitting a prescription electronically to the pharmacy. The project provides a community health record to FG providers at 20 sites in Sedgwick County.

Cost: **Kansas HIT/HIE Policy Initiative** – FY07 $30,000 SGF $40,000 In-Kind
Privacy and Security Collaboration – FY07 $32,126 In-Kind
Advanced ID Card Project – FY07 $45,000 SGF
Community Health Record (CHR) Project – FY07 $250,000 SGF ($500,000 all funds) $48,000 SGF for project evaluation. Project extension figures are provided in separate document.

Staff Recommendation: Fund for Enhancement for FY 2008.

Board Action: Motion made, seconded and carried to approve for FY 2008 Enhancement funding.

Studies funded through an **Enhancement for FY 2008**

Policy Option: Study ePrescribing for Inclusion in the Medicaid program

Description: Study and provide recommendations for e-prescribing incentives for Medicaid providers to transmit prescriptions electronically.

Background: ePrescribing is the electronic transfer of a prescription from the prescriber to the dispensing pharmacy. It can drastically reduce medication errors by eliminating problems due to illegible handwriting and providing decision-support tools that automatically alert providers to interactions, allergies, and other contraindications. A July 20, 2006 Institute of Medicine (IOM) report detailed medication errors that harm 1.5 million people every year and cost $3.5 billion per year to treat. ePrescribing is efficient and reduces the amount of time physicians and pharmacists spend clarifying medication orders, as well as reducing prescription fraud. The IOM report calls for all prescriptions to be written electronically by 2010. However, there are start-up costs to providers for electronic health record systems that enable ePrescribing. Once the software and hardware are in place, there are limited administrative costs associated with ePrescribing. Some payers have been offering providers software and hand-held computers for free or at a discount, cash incentives to use technology.

Population Served: All Medicaid beneficiaries taking prescription medication and Medicaid providers and pharmacies.

Cost: $10,000 plus staff time. Direct costs includes expense of stakeholders meetings and a site visit, with additional cost of two consultants to participate in the study.

Considerations: The Center for Medicare & Medicaid Services (CMS) has begun implementing e-prescribing provisions of the Medicare Modernization Act by issuing standards that help to ensure consistency and efficiency in ePrescribing. CMS is also conducting e-prescribing pilot projects to improve patient safety by improving the efficiency of providing prescription drugs and using electronic messaging standards to ensure pharmacists, physicians and their staffs have the information they need about a patient's history. CMS is currently offering states $150 million in grant funding in 2007 and 2008 for transformation projects, including ePrescribing. KHPA intends to submit a proposal.

There are a number of Health Information Technology (HIT) and Health Information Exchange (HIE) initiatives in Kansas that can to promote e-prescribing. Although most physician practices do not have Electronic Health Records (EHRs), the Health Care Cost Containment Commission (H4C) and other HIE stakeholders are currently working to quantify and describe which of the 6000 practicing physicians in Kansas have EHRs. Kansas does possess an infrastructure to provide broadband internet access to hospitals and libraries through KanED. This infrastructure could be used to connect rural providers, but would require a legislative change.

A number of legislators have expressed support for e-prescribing in the Kansas Medicaid program. Research needs to be done to ensure that any implementation of an e-Prescribing program for Kansas Medicaid utilizes the developing CMS standards that help to ensure consistency and efficiency in ePrescribing and include stakeholder input from physicians, pharmacists and beneficiaries.

Staff Recommendation: Fund study for Enhancement FY 2008. Fund implementation of e-prescribing program in FY 2009.

Board Action: Motion made, seconded and carried to remove this option from the FY 2008 Enhancement package and instead include in the "Non-State General Fund Program and Policies" for FY 2007/2008 implementation.

Policy Option: Study consolidating prescription drug assistance programs across Kansas

Description: The Kansas Health Policy Authority should study the potential of consolidating state prescription assistance programs to ensure efficiency in administration and leverage volume purchasing. Additionally, KHPA should consider partnering with local community based programs analyze potential opportunities for partnering and obtaining greater efficiencies and discounted pricing for pharmaceuticals.

Background: There are a number of prescription drug assistance programs in Kansas funded by the State. These include the Medication Support Program through SRS, which pays for atypical antipsychotic medication for the uninsured (FY 07 funding $1,050,000); CommunityRx Kansas (FY 07 funding $400,000), which provides access to discounted medications through local pharmacies to the uninsured up to 300 percent FPL; and 340B prescription programs in safety net clinics, with funding distributed through KDHE for clinics to establish or enhance their prescription assistance programs.

There are also local programs funded through city and county governments, like Project Access in Wichita and Health Access in Topeka. Project Access has agreements with local providers for discounted prescriptions. Another type of community-based program is a voucher or reimbursement program, like the Community Health Council of Wyandotte County.

There are state models that have been effective in consolidating prescription drug assistance programs. In South Carolina, Communicare coordinates a network of health providers and pharmaceutical companies who donate services and prescriptions to low-wage, uninsured citizens who qualify. Communicare was formed in 1993, with a combination of foundation and state funding, and was established as a non-profit in 1997. In 2004, Communicare dispensed approximately $24 million in donated prescription drugs through the William Murray central fill in-house pharmacy (average 700 per day). Originally designed to serve as a centralized prescription assistance program, dispensing free drug from manufacturers, the program has expanded to include physician and dental services, matching patients up with needed services donated by the medical community.

Population Served: Kansans who lack prescription drug coverage.

Considerations: There is significant concern among Kansas seniors of low income who previously had access to pharmaceuticals through various community and industry programs. Consolidation of these programs, such as the South Carolina model, can help to centralize these assistance programs and help dispense pharmaceuticals to Kansans in need. The doubling of funding in the CommunityRx Kansas program by the 2006 legislature shows support for helping to provide pharmaceuticals to low income citizens.

Cost Estimate: $7500 plus staff time. Direct costs include development of prescription program consolidation plan, expense of stakeholders meetings and a site visit, with additional cost of two consultants to participate in the study.

Staff Recommendation: Fund study and proposal development for FY 2008.

Board Action: Motion made, seconded and carried to remove this option from the FY 2008 Enhancement package and instead include in the “Non-State General Fund Program and Policies” for FY 2007/2008 implementation.

Policy Option: Study Workforce Shortage in Rural and Underserved Urban Kansas

Description: Telemedicine, Telehealth, and the use of medical extenders are just a few of the health policy initiatives aimed at increasing access to health care services by extending the capacity of the health care workforce, often in rural and underserved urban Kansas. The Kansas Health Policy Authority proposes to study and make recommendations on policies to encourage an adequate health care workforce in rural and underserved urban Kansas, building on the findings from on-going initiatives such as at the Kansas Board of Regents Nursing workforce study, the Physician Workforce Advisory Group, KDHE's Local Public Health Workforce Needs Assessment, the United Health Ministry Fund's initiative to increase the supply of Kansas dentists, etc. Such a study should examine disparities in access.

Background: A shortage of physicians, nurses, pharmacists, dentists, and other health care professionals is projected for most rural states in the US. This shortage was predicted as the aging population continues to grow, increases in technology and pharmacy treatment options allow Kansans to live longer, and the pool of traditional and non-traditional students in the health professions has declined. This is more pronounced in rural communities and in some underserved urban communities, creating disparities in access to health and health status in these populations. In a 2003 GAO report on the physician workforce, persistent disparities in physician supply were found between metropolitan and non-metropolitan areas, particularly in states like Kansas. In 2001, there were 278 physicians per 100,000 people in Kansas metropolitan areas compared to only 114 physicians per 100,000 in non-metropolitan Kansas. The nursing workforce in Kansas is also of concern. For the past seven years Kansas has experienced a decline in nursing school enrollments and graduations. Many RN's have left the workforce burned out and dissatisfied with their increasingly demanding jobs. Increasing the supply of dentists in Kansas is also a priority as one third of Kansas counties are considered Dental Health Professional Shortage Areas, most in rural areas.

There are a number of initiatives at the state and federal level to encourage health care providers to practice in rural areas and some underserved urban areas. However, as the budget deficit grows at the national level, funding for federal programs has been cut significantly in the last four years. In the state of Kansas, the Medical Student Loan Program has been successful in recruiting medical students to practice primary care in rural areas and receives enthusiastic support from the legislature and Governor, but student interest in the program has recently leveled off. A new program funded by the 2006 legislature and advanced by the Kansas Board of Regents to increase the level of nurses by 25% over the next ten years is an encouraging commitment to ensure an adequate supply of nurses for Kansas.

Telemedicine also extends the reach of health services to individuals residing in rural health professional shortage areas and counties outside of Metropolitan Statistical Areas (MSA). Kansas has a successful Telemedicine and Telehealth program which provides 3,000 telemedicine consultations per year, 25% of which are rendered to Medicaid beneficiaries. Medicaid coverage of telemedicine services began August 13, 2004. Telehealth, which involves the collection of clinical data and the transmission of such data between health care providers (Home Health Agencies) and patients and /or caregivers in the home setting, is currently provided on a small scale to individuals with chronic illnesses such as CHF (Congestive Heart Failure), COPD (Chronic Obstructive Pulmonary Disease), Diabetes, and Mental Illness for medication management. Many of these individuals reside in underserved areas in central and west central Kansas.

Population Served: Rural and some underserved urban communities in Kansas.

Cost Estimate: $150,000 SGF This study will be contracted and includes the salary and fringes of the contractor as well as the expense of stakeholders meetings.

Considerations: The issue of the health care workforce is a focus of many national and federal organizations. However, many of the initiatives are aimed at increasing the supply of health professionals within a single profession. The Kansas Health Policy Authority, given its broad mandate to improve health policy for the state, is well placed to convene a diverse set of health professional stakeholders to encourage a comprehensive health workforce plan for the state.

Staff Recommendation: Fund study for FY 2008.

Board Action: Motion made, seconded and carried to approve for FY 2008 Enhancement funding.

Policy Option: Medicaid Beneficiary Wellness Study

Description: Before proposing incentive programs for Medicaid beneficiaries for healthy behaviors, some research will be conducted that includes surveying members of the population and conducting focus groups to learn what the barriers are to health and fitness. Such research would also make it possible to gauge the potential response of beneficiaries to various incentives. Basic behavior modification research has demonstrated that the subject determines what is rewarding or reinforcing; the researcher should never assume he or she knows what will reinforce behavior.

Background: Since Medicaid claims data do not contain lab results, weight information and other clinical indicators of wellness and fitness, we cannot observe how policy variations might impact beneficiary wellness.

Medicaid beneficiaries belong to the poor and working poor; assumptions that may be true of the middle class concerning wellness and fitness behaviors may not apply. For example, a single mother with small children may simply find it difficult to exercise because she has no childcare and lives in an unsafe neighborhood.

KHPA will need to partner with qualified entities that can assist in creating and disseminating surveys, conducting focus groups and analyzing the information collected from the target population of Medicaid eligibles to determine their state of wellness and gauge their potential response to various incentives.

Population Served: The Medicaid and SCHIP population will be directly affected by this initiative.

Cost Estimate: $87,500 (SGF); $175,000 (All Funds) plus in-kind staff support

Considerations: Before implementing any initiatives deriving from this study, measures of wellness and fitness would need to be identified and a plan for obtaining those measures reliably will need to be made for the Medicaid population.

A significant percentage of the Medicaid and all of the SCHIP population will be in managed care by January 2007 and so the managed care organizations (MCO's) will be responsible for helping the members behave in healthier ways. However, CMS limits what MCO's can do in offering incentives to their members.

Staff Recommendation: Fund for Enhancement for FY 2008.

Board Action: Motion made, seconded and carried to approve for FY 2008 Enhancement funding.

Non-State General Fund program or policy proposals for **FY 2008**

Name of Policy: **Health Data Consortium**

Description: Creation of a Health Data Consortium which will include a wide variety of stakeholders who will advise the Kansas Health Policy Authority board on the development of indicators

Background: The Authority is charged with the responsibility for a wide range of health and health data that includes both programmatic, or administrative, information and non-programmatic data, and is charged with using and reporting that information and to increase the quality, efficiency and effectiveness of health services and public health programs. The Authority is specifically required to adopt health indicators and include baseline and trend data on health costs and indicators in each annual report submitted to the Legislature.

Programmatic data.

- Medicaid
- state employees health benefits plan
- state workers compensation self-insurance fund

Non-programmatic data.

- inpatient hospital claims information
- health care provider database
- Kansas Health Insurance Information System (KHIIS) -- private insurance data

The Kansas Health Policy Authority is to ensure the effective collection, management, use and dissemination of this data to improve decision-making in the design and financing of health care and public health and wellness policies. To help meet the Authority's responsibilities in this area, the Executive Director will convene and direct the Data Consortium. The Consortium is to advise the Authority in the development of policies and bring recommendations to the Authority for consideration. The Data Consortium will provide recommendations and input in a number of areas:

- the Authority's responsibilities for managing health data
- reporting standards and requirements for non-programmatic data
- data sharing for research, policy development and programmatic improvement
- identifying specific topics for analysis
- health and health care data initiatives in other organizations and agencies
- reporting cost, quality, and other data for consumers, policymakers, and others

Population Served:
All Kansans. Initial datasets include hospital records for the entire population, all licensed health care providers, and comprehensive insurance and claims information for all privately-insured (non-ERISA) individuals, state employees, and Medicaid recipients.

Cost: No additional SGF.
KHPA will provide all staff support for the Data Consortium and resources for this purpose as reflected in the **Data Management and Policy Analysis Program** proposal. The Consortium will be supported primarily by the staff and Director of the Data, Policy and Evaluation division.

Board Action: Motion made, seconded and carried to approve for FY 2007/2008 implementation.

Policy Option: Improving Workplace Health and Wellness within the State Employee Health Plan

Proposal: The Kansas Health Policy Authority (KHPA) is interested in expanding our focus on health and wellness policies within the State Employee Health Plan (SEHP). Current policies feature multiple programs offered by the state plan (HealthQuest), insurers, or both. A single KHPA employee currently coordinates all these programs under the authority of HealthQuest. We struggle to track participation in these programs and are unable to judge their effectiveness. Our employees are at substantial risk for Atherosclerosis, Diabetes Mellitus, and the surgical complications of Osteoarthritis and we do not analyze data for health disparities by gender, race or ethnicity. These health conditions are among the largest current and future liabilities for the State Employees Health Plan (SEHP).

Background: The increasing cost of treating chronic disease is a significant factor in leading to an unsustainable rate of growth in medical inflation. Unhealthy behaviors are significant risk factors for most chronic diseases. We propose to significantly increase the focus on health and wellness in the State Employee Health Plan for the 2008 plan year with the goal of improving health and decreasing overall health costs. This will include: incentives to participate in a new HRA (Health Risk Appraisal) with a focus on health behavior, chronic disease management plan, improved fitness, improved nutrition, and smoking cessation. We propose to collect data on all willing current employees and new employees. We will offer incentives for improvement in BMI, fitness and smoking cessation. The HRA will include a questionnaire with subsequent risk-scoring. The risk-score will indicate individuals' target areas for improvement and provide information on nutrition, alcohol, tobacco, seat belts, etc. The HRA would then provide high risk employees with links to condition-specific resources and support, and employees could choose to receive follow up health and wellness information on a regular basis. The tobacco premium surcharge will resume. Additionally, we will measure health disparities for chronic disease and wellness indicators in order to better understand disparities in the SEHP population and ensure that these wellness programs are targeted to those individuals in greatest need.

In addition, KHPA staff will partner with KDHE on a comprehensive employee health and wellness plan for the entire state. For example, we will be working together to implement a comprehensive smoking cessation initiative that provides incentives for employees to quit and provides them resources to do so. We plan to partner with additional agencies and community organizations to promote workplace wellness.

Considerations: Previous incentives for participation in wellness activities in the SEHP have been effective. In 2003, HealthQuest offered employees a health risk appraisal with a small incentive for participation ($10 per month health insurance premium discount for one year). Over half of employees participated (20,500 out of 36,000 benefits eligible employees) and important data were collected. Also, at that time, smokers paid higher premiums than non smokers. Since 2003, the premium differentials and the HRA have been discontinued. Some employees may question the link between premiums and health risks. Workable validation mechanisms would need to be developed.

Population Served: State employees initially, but the goal will be to generalize to the Kansas population.

Cost: The SEHP is self funded, so there will no additional SGF costs.

- We can assume participation in the HRA will be similar to 2003-2004, when HRA costs were $580,542 and $618,571, respectively. The health screening and HRA unit costs in 2003 and 2004 were $25 and $5, respectively.
- The timed fitness test and incentives (premium reduction) could add an estimated $2.5 million, for a total annual cost of $3.25 million. Some (or all) incentive cost would be offset with increased premiums for smokers.
- In partnership with KDHE, we will consider other workplace plan models that might prove to be effective for the SEHP population.

Staff Recommendation: Support increased focus on health and wellness in the State Employee Health Plan as a means to promote health, decrease chronic disease and reduce health disparities.

Board Action: Motion made, seconded and carried to approve for FY 2007/2008 implementation.

Name of Policy: **Re-tool the Small Business Health Partnership**

Description: Re-tool the Small Business Health Partnership Program in collaboration with the Kansas Business Health Policy Committee (KBHPC) to improve the accessability and affordability of health insurance for small businesses.

Background: Over the 2004-2005 period, the KBHPC engaged in a grant-supported study and planning exercise to generate a proposed pilot program of subsidized and facilitated purchasing of health insurance for small businesses. The group identified small businesses as a key target for reaching a large number of working uninsured throughout the state. State-level research and a variety of in-state and out-of-state advisors suggested that the most promising initiatives for increasing coverage in the state would target subsidies to low-income workers in small businesses.

In Spring 2006 the KBHPC sought and received bids for a carrier to offer insurance to new or existing small businesses (2-25 employees) that have not offered health insurance to their employees during the previous twenty-four months. Employers and benefits-eligible employees whose families have incomes less than 200% of the federal poverty level (FPL) would also be eligible to receive financial incentives from the state to help pay premiums for the awarded plan. Contribution rates would begin at 10% of the premium for employees and 30% for employers, leaving 60% as the state's share.

We are proposing to reconvene the Kansas Business Health Policy Committee and build on the significant amount of study and planning that created the pilot program. We propose to revisit the design of a pilot program, incorporating results from an ongoing Kansas Insurance Department study of the use of reinsurance to further reduce the barriers that small businesses face in providing coverage to their employees as well as the Massachusetts Health Connector program.

Population Served:
The pilot program was to be offered in Sedgwick County on a pilot basis and would have covered about 1,000 employees in the first year, 1,500 over a two-year program. The KBHPC will revisit the design, scope and location of a pilot and determine whether a pilot program or statewide implementation is most appropriate.

Consideration:
2006 Session did not fund this project. An RFP was issued in Spring 2006 and responses were received. The RFP was cancelled due to lack of funding. The legislature did not fund this $2 million pilot program.

Cost: No SGF Cost. KHPA provides the staff for the KBHPC.

Board Action: Motion made, seconded and carried to approve for FY 2007/2008 implementation.

Name of Policy: **Study Deficit Reduction Act (DRA) Flexibilities for Kansas**

Description: Convene a working group of key agency leadership to assess the flexibilities provided to States in the recently passed Deficit Reduction Act (DRA) for planning and implementation of reforms in 2007 and 2008 and design a Medicaid Reform plan for Kansas.

Background: The Deficit Reduction Act (DRA) gives States more flexibility to design Medicaid benefits that efficiently and affordably meet their states' needs, and tightens the loopholes that allowed people to transfer assets to their children so they can qualify for Medicaid benefits. Some of the provisions in the DRA are mandatory and States have begun to implement the provisions per the statute. However, many of the CMS rules and regulations for the new optional Medicaid flexibilities are still in development. Accordingly, a work group of leadership staff from the Kansas Department on Aging, the Kansas Department of Social and Rehabilitation Services, and the Kansas Health Policy Authority will convene to determine how Kansas can best use these new opportunities to improve the health of Medicaid beneficiaries and more effectively use Medicaid resources.

Designing a Kansas Medicaid reform plan that fully utilizes DRA flexibilities in a coordinated manner is important to the long term sustainability of the program. The DRA Workgroup will be convening groups of stakeholders to understand their unique perspectives regarding potential policy changes to Kansas Medicaid and anticipate robust discussion. Consumer input into the process is crucial. Assessing the needs of stakeholders, studying the various options available to the State and receiving guidance from CMS are key steps in ensuring that Medicaid reform in Kansas will be a rationale process with clear policy objectives.

Cost: No additional SGF funding is needed.

Considerations: The Governor and legislature are eager for the State to utilize some of the new opportunities available to strengthen and improve the Kansas Medicaid program. Convening a DRA Workgroup of agency leadership that ensures public participation will ensure a thoughtful planning process that will improve the Kansas Medicaid program for beneficiaries and providers.

Board Action: Motion made, seconded and carried to approve for FY 2007/2008 implementation.

Background: Programs or policies for **funding consideration for FY 2009**

Policy Option: Expand Medicaid for Working Adults

Description: This change would expand Medicaid eligibility by increasing the income limit for family medical coverage to 100% of the federal poverty level. The current income threshold is based on payment limits in the Temporary Assistance for Families (TAF) cash assistance program. The current TAF cash payment amount is about 29% of the federal poverty level. For a family of three, the annual income limit would increase from about $4,850 to $16,600.

Low-income families receiving medical assistance for at least three months who become ineligible due to earnings usually qualify for Transitional Medical Assistance, or TransMed. An additional 12 months of coverage is provided to these working families if their income remains under 185% of poverty (about $30,700 for a family of three). Increasing the family medical population would also increase the population eligible for TransMed.

Population Served: The new limits would apply to low-income families with children, including those with non-parent caretakers. Because poverty level Medicaid and HealthWave XXI currently provide coverage to children at these income levels, the expansion would primarily involve the adult caretakers. Most of the adults potentially eligible are currently uninsured. Members of this population group are subject to Managed Care enrollment.

Costs: There are an estimated 30,550 adult caretakers in families below the poverty level who would be potentially eligible for expanded coverage. If 70% chose to participate, an additional 21,380 persons would be covered. At $217 per beneficiary the cost would be approximately $55,680,000 (all funds) of which $22,210,000 would be SGF.

Additional resources would be needed for administrative costs associated with the expansion, such as changes in automated computer systems. Additional eligibility staff will also be needed.

Considerations: Medicaid rules do not allow the state to strictly limit an expansion of the existing coverage group to working parents. However, additional earned income disregards may be used to cover a higher percentage of working families in the expansion. A different income threshold may be used, for example 75% or 125%.

The existing income limit for this group has been in place since 1993. At that time the payment standard for a family of three was approximately 41% of the federal poverty level. The effective poverty level continues to decrease each year as no cost of living adjustments are made under the current income structure.

If the State sought an 1115 waiver, there would be some greater flexibility in covering this population.

Staff Recommendation: Consider funding other expansion models, which either target a lower FPL threshold or use an 1115 waiver, for FY 2009.

Board Action: No action taken; for review and consideration by the Board at a later date.

Policy Option: Pay for Performance for Kansas Medicaid

Description: We propose a system of incentive payments, shared between Medicaid patients and their physicians, which would reward providers who adhere to accepted best practice guidelines for health care, as well as measures that demonstrate a focus on wellness, such as improvements in fitness (measured by a 12 minute walk), BMI, blood pressure, or Hemoglobin A1C. Patient payments could be in cash or as vouchers.

Background: Quality of health care services and health and wellness indicators fall short of established benchmarks in both private and public sector. Despite the fact the US spends almost double what other industrialized nations spend, we still have an unacceptably high rate of medical errors and rank poorly on a number of population health indicators. The current methods of reimbursement for health care providers, fee-for-service and capitation, offer no specific payment incentives for providing high quality of care. In a recent New England Journal article, the authors found that "US patients receive proper medical care from doctors and nurses only 55% of the time, regardless of their race, income, education, or insurance status…a well functioning system should achieve 80 to 90%".

Accordingly, over 150 Pay for Performance (P4P) initiatives have been developed by the federal government, insurers, employers, and coalitions of health care stakeholders. These P4P initiatives change current payment methodologies to reimburse providers at higher levels for care consistent with evidence based medicine, typically with a focus on clinical processes and patient outcomes. At the national level, there is significant interest but limited coordination between these organizations. Guidelines from JCAHO, AMA, AAFP, AHIP are being developed, a taxonomy is being developed by AHRQ, and the IOM is finishing recommendations on P4P by the end of the year. Currently these initiatives focus on reimbursement for different providers, such as physicians, hospitals, nursing homes, and may have differing objectives, such as rewarding quality, improving quality, cutting costs, reducing waste, avoiding unnecessary care, improving patient satisfaction, reducing disparities, fostering innovation, and encouraging IT adoption.

Considerations: Because various guidelines, taxonomy, and recommendations are being developed by national groups over the course of the next year, it may be prudent for states to wait for more direction and clarification from CMS regarding P4P. Currently there is not agreement as to whether P4P: (1) helps to improve "low performers", and not just reward already high performers, (2) ensures that providers with sicker and less adherent patients benefit from P4P, (3) ensures that the outcomes of implementing these systems justify the costs; and (4) is actually transforming the overall health system and impacting outcomes. Additionally, there is significant political push back from some provider organizations.

Population Served: Kansas Medicaid patients and their physicians

Cost: Depends directly on the size and number of bonus payments for specific measures.

Staff Recommendation: Wait for national guidelines from CMS and other stakeholder groups and assign the Data Consortium to consider P4P proposals for Kansas. Consider funding for FY 2009.

Board Action: Motion made, seconded and carried to remove this option from the FY 2009 Funding Consideration package and approved for FY 2007/2008 implementation. There was one dissenting vote cast by Dr. Vernon Mills who indicated concern that performance measures have not yet been developed and added that additional issues need to be addressed.

Policy Option: Quality Measures in the New MCO contracts for HealthWave

Description: The current contracts include required reporting of HEDIS (Health Plan Employer Data and Information Set) and CAHPS (Consumer Assessment of Healthcare Provider and Systems) measures. The new contract will require continued reporting of HEDIS performance measures and CAHPS by the MCOs.

Currently, HEDIS performance measures reported on annually by the HealthWave MCO for HealthWave 19 and 21, including Children with Special Healthcare Needs are:

- Use of Appropriate Medications for People with Asthma;
- Adolescent Well Care Visits, Well Child Visits in the First 15 Months;
- Well Child Visits in the 3rd, 4th, 5th, and 6th Years;
- Inpatient Utilization –General Hospital/Acute Care;
- Outpatient Drug Utilization;
- Children and Adolescent's Access to Primary Care and;
- Prenatal and Postpartum Care.

For HealthWave 19 including Children with Special Healthcare Needs, the HealthWave MCO also reports on performance measures of:

- Comprehensive Diabetes Care, and
- Cervical Cancer Screening.

CAHPS is a nationally standardized survey tool developed to assess the level of satisfaction with access, quality and timeliness of care received by beneficiaries by the MCO plan and their providers. The tool also obtains data about the overall satisfaction regarding the health care members receive from their MCO.

Population Served: HealthWave MCO contracts are for Title 19 and Title 21 HealthWave members. This population consists primarily of pregnant women, children and a few men. This population is considered to be the healthier group of beneficiaries served in the Medicaid program.

Cost: The cost for HEDIS and CAHPS is included in the Capitation rate paid to the MCOs. The MCOs report currently on well child exams, eye exams and immunizations. Completion of the CAHPS survey and HEDIS performance measures is all-inclusive with the administrative cost of managing the contract(s) for Title 19 and Title 21 HealthWave members. Reporting on HEDIS performance measures and CAHPS is a federal requirement and is not an itemized cost made by the HealthWave MCO when bidding on the contract.

Considerations: The current HealthWave MCO contract expires December 31, 2006. RFP responses for future HealthWave MCO(s) were received on June 16, 2006. The Managed Care team is currently evaluating all of the responses with the contract award(s) tentatively scheduled August, 2006. If additional wellness reporting items, or different ones, are needed, amendments to the RFP can be developed after contract award.

Staff Recommendation: Fund for FY 2009; have Data Consortium develop key indicators.

Board Action: No action taken; for review and consideration by the Board at a later date.

Policy Option: Primary Care Case Management Incentive for Medicaid

Description: Primary Care Case Management would provide incentives to Medicaid primary care providers through financial (bonuses, performance fee schedules or grants) or non-financial means (performance profiling and publicizing performance), or both. The State would set clinical measures such as mammogram, Pap smear, or immunization rates. The provider would be rewarded for providing the clinical measures at, or exceeding, the rates set by the State. Current provider reimbursement does not reward for quality or performance; an incentive program would focus on quality and performance.

Several states have pursued primary care case management incentives. California spent three years in planning and implemented their program in 2005. Four patient satisfaction measures and six clinical measures were set by the state. Each managed care organization made the decisions about source and amount of performance-based payments. A waiver was not required as the program was implemented through the managed care organizations contracts. Rhode Island adopted 22 administrative, access and clinical measures utilizing an 1115 waiver. A 33% decrease in hospital days and emergency room use was seen in the first year. One of the managed care organizations set aside $1.5 million for physician bonuses for one year's time frame. Arkansas releases a "physician report card" so provider's can compare referrals, hospitalizations, and emergency room use. Maine measures well-child visits and immunizations and provides bonuses to providers who perform a high number of these services. Wisconsin has used performance measures and provided incentives for child health services. They also withhold a portion of payment to managed care organizations if standards for lead exposure, developmental problems or vision difficulties are not met.

Kansas would need to decide to pursue waiver options or new contracts with managed care organizations for such an incentive program. The current primary care case management program, Health Connect, does not provide incentives to physicians and would see a significant decrease in enrollment (85,400 to approximately 10,000 people) if two or more managed care organizations provide services beginning January 2007.

Costs: Cost estimate should include the additional staff and years in planning, writing and implementing a Medicaid waiver, or negotiating new contracts with managed care organizations. The number of measures set by the State and the decisions on how to provide incentives to providers would be additional costs. As mentioned above, one managed care organization set aside $1.5 million in incentive pay for their providers for one year. No cost estimate for the implementation of the program from another state could be located.

Considerations: The evaluation of the Enhanced Care Management Program pilot in Sedgwick County could provide data to inform this proposal. The quality and wellness measures, as well as the financial and non-financial rewards would need considerable planning and input from multiple sources. The populations served could be limited or state wide, dependant on the above decisions. The initiation of an incentive program is a long-term process and a minimum of three years to plan would be essential to obtain physician and managed care plan buy-in. New contracts for managed care organizations in the State will be effective January 1, 2007; time would be needed to change these contracts or let them expire. A waiver process is also time-consuming and requires considerable oversight to meet CMS standards and reviews.

Staff Recommendation: Fund for FY 2009; need measures developed by Data Consortium.

Board Action: No action taken; for review and consideration by the Board at a later date.

Policy Option: **Use of Medicaid Mailings to distribute health information**

Description: Medicaid pays for a variety of mailings. These mailings could be used to send out health and wellness information. Some could be targeted to specific disease or populations with specific concerns.

Consider inclusion of health information with:

1- Mailing of monthly medical cards using the medical card stuffer process
2- Mailing of enrollment packets to managed care eligible beneficiaries
3- Mailing of benefit booklets to all beneficiaries
4- The HealthWave application.

Separate special mailings are also an option.

Population Served: Medicaid, MediKan and Title XXI population (medical cards option is not available to Title XXI population)

Consideration: In 2006, notices or "stuffers" went out with medical cards 5 months out of 7. KDHE sent 2 of the 5 notices to educate on smoking cessation and lead safety. Notices or stuffer activity can be found on the beneficiary page of the KMAP website. The HealthWave applications are widely distributed to doctors' offices and other community partners. It would be difficult to keep the information updated everywhere.

Consider conducting a study regarding the effectiveness of informational mailings to beneficiaries.

Cost:

	All Funds	FFP	SGF
Survey	$100,000	$50,000	$50,000
Printing/ inserting	$12,000	$6,000	$6,000
Postage	$74,000	$37,000	$37,000

Estimated costs for one mailing are based on a population of 200,000, using black and white copies, one pager. Information sent out using existing mailings would result in no additional postage cost as long as it does not cause the mailing to move to a higher postage bracket. Printing and inserting cost would be incurred. Special mailings would generate postage, printing and inserting costs.

Staff Recommendation: For future consideration in FY09; link all marketing activities by developing a comprehensive marketing strategic plan to distribute wellness, eligibility or program specific information, such as Kan-Be-Healthy information, to consumers. Partner with KDHE and other related agencies when possible. After each mailing, an evaluation should be completed which would measure the effectiveness of the material in delivering the desired message.

Board Action: No action taken; for review and consideration by the Board at a later date.

Policy Option: Kan Be Healthy (KBH) Marketing

Description: The purpose of any proposed marketing policy for KBH is to make KBH a well-known product. Currently, consumers confuse it with Healthwave, FirstGuard and Health Connect Kansas and many providers confuse it with services that may be fractured into several pieces over several agencies, and thereby lose the medical home concept as well as dilute the billing and data collection for each visit. The proposal will include designing a logo for KBH that is easily recognizable for providers and consumers, similar to the, "Bee Wise, Immunize!" The proposal will also include a section on marketing the "KBH Screening Form" to all Kansas children. The KBH Screening Form and Standards of Practice are well-researched, best practices and have the potential to become an electronic record. All elements of the form that are required to be in the KDHE Registry are already available on the KBH Screen.

Population Served: All Medicaid eligible children, birth through age 20. FFY KBH Screening Rate was 53.3% and the target goal is 80%.

Cost Estimates: Healthwave has previously had a marketing annual budget of $220,000.00. It is estimated that this will require at least this much as a start up cost. This will include Product Image, possible consumer task force meetings, advertising and promotion, printing and trials of products.

Considerations: Healthy Kansas 2010 have goals of blood lead testing and vaccinations on time and documented, and the KDHE registry is an adjunctive tool that will collaborate well with this product as it grows in the future.

Staff Recommendation: For future consideration in FY09; link all marketing activities by developing a comprehensive marketing strategic plan to distribute wellness, eligibility or program specific information, such as Kan-Be-Healthy information, to consumers. After each mailing evaluation should be completed which would measure the effectiveness of the material in delivering the desired message.

Board Action: No action taken; for review and consideration by the Board at a later date.

Name of Policy: **Reinsurance for high cost beneficiaries**

Description: Develop and implement a re-insurance program for high cost beneficiaries in the State of Kansas.

Background: Reinsurance is "stop-loss" insurance that insurers themselves or self-insured employers can purchase (or be given) that covers losses above certain thresholds incurred by individuals and/or the group as a whole. State reinsurance programs can serve small groups in the way that high-risk pools serve individual market. Analysts have suggested that insurer's risk selection activities (e.g., targeted marketing, stylized benefits) are not profitable except for the highest-cost 2-3% of individuals in their potential book of business. Reinsurance lowers insurers' exposure for the most expensive individuals and thus lowers the profitability of risk-selection activities, potentially rendering individual and small-group markets more open (and less costly) to higher-risk individuals and groups. In this way, reinsurance can lower the risk premium charged to small groups, i.e., small businesses, by reducing the insurer's exposure.

- Connecticut operates a voluntary individual and small-group reinsurance product whose premiums (about $4,500 per covered life) are funded by a market-wide assessment (less than 1% of all small group premiums). This is the National Association of Insurance Commissioner's model program. Idaho and Massachusetts also operate reinsurance programs funded through insurance assessments. Enrollment in unsubsidized state plans tends to be small (e.g., 4,000 or less per state).
- New York and Arizona rely on general tax funds to subsidize small-group insurance pools through reinsurance. Enrollment in state-subsidized plans tends to be larger.

Population Served:
Specific programs have not yet been designed. Reinsurance and other subsidies could be piloted in a specific area or could be implemented statewide. Reinsurance could be limited to small businesses participating in the KBHPC program, or could be made more generally available.

Consideration: The Insurance Commissioner is sponsoring a Federally-funded study of the potential use of reinsurance to increase coverage in Kansas. The study is using the KHIIS data to estimate the potential impact. Policy options under consideration include those in use in New York, Connecticut, Arizona, Idaho and Massachusetts. A number of technical issues remain before implementation.

The KHPA would plan to reconstitute the Kansas Business Health Policy Committee (KBHPC) and revisit the design of a pilot program, incorporating existing plans for benefit design and subsidy targets with the ongoing study of the use of reinsurance to develop a comprehensive proposal for increasing insurance coverage in the state.

Cost: Development of a proposal through the KBHPC.

Staff Recommendation: Funding for FY 2009.

Board Action: No action taken; for review and consideration by the Board at a later date.

Policy Option: Develop and Implement a Nurse Help Line

Description: Create a Medicaid nurse help line for beneficiaries to call with primary health care questions or health information. This could deter more expensive office or emergency room visits.

Background: Providing Medicaid beneficiaries with a "nurse line" that they could call with medical questions may be a useful tool in providing important health information and minimizing unnecessary visits to the emergency room.

Population Served: Medicaid beneficiaries in Kansas..

Cost Estimates: Call line would need an updatable computerized system to provide standardized answers for any type of question and a dedicated toll-free phone line. Program should be staffed by a registered nurse 24 hours per day, 7 days a week.

- Children's Mercy estimates $185,000 for the computer system and around $18,000 for updated annually. Estimated cost for the program around $1million dollars.

- St. Francis Hospital in Topeka estimated the annual costs were around $750,000/year. Computerized system costs $100,000.

- Stormont-Vail's estimated annual operation costs are $907,000.

Considerations: Several hospitals in the area either have or have historically had "nurse help lines" for their patients. Descriptions of the these programs include:

* Children's Mercy has no plans to discontinue the Ask-A-Nurse program. They have an 18 member Advisory Board for the program. They feel it is good for the community.
* Wesley Hospital decided not to implement because of liability concerns.
* St. Francis in Topeka discontinued program several years ago due to the cost of upgrading computerized system and systems problems. They felt like it was a good marketing tool.
* Stormont-Vail's program is called Healthy Connections. It is operational from 4:30 pm to 8 am Monday thru Friday and 24 hrs on Saturday and Sunday. They have a computerized system.
* KHPA could develop and operate our own program. Physical space would be needed.
* Could contract out to a vendor through an RFP process.
* Maybe difficult to recruit registered nurses.

Staff Recommendation: Consider funding for FY 2009 or future; combine with feasibility study of inclusion of other nurse help-lines; research what other states are currently doing in this area.

Board Action: Motion made, seconded and carried to remove this option from the FY 2009 Funding Consideration package and approved for FY 2007/2008 implementation.